Washington State Department of Health

**Immediately notify**
DOH Communicable Disease Epidemiology
**Phone: 877-539-4344**

# Botulism, infant

**County**

**LHJ Use** **ID** _____
☐ **Reported to DOH** **Date** ___/___/___
**LHJ Classification** ☐ **Confirmed** ☐ **Probable**
**By:** ☐ **Lab** ☐ **Clinical** ☐ **Epi Link:** _____

☐ **Outbreak-related**
***LHJ Cluster#*** _____
***LHJ Cluster Name:*** _____
***DOH Outbreak #*** _____

## REPORT SOURCE

LHJ notification date ___/___/___
Investigation start date: ___/___/___
Reporter (check all that apply)
☐ Lab ☐ Hospital ☐ HCP
☐ Public health agency ☐ Other
OK to talk to case? ☐ Yes ☐ No ☐ Don't know

Reporter name _____
Reporter phone _____
Primary HCP name _____
Primary HCP phone _____

## PATIENT INFORMATION

Name (last, first) _____
Address _____ ☐ Homeless
City/State/Zip _____
Phone(s)/Email _____
Alt. contact ☐ Parent/guardian ☐ Spouse ☐ Other Name: _____
Zip code (school or occupation): _____ Phone: _____
Occupation/grade _____
Employer/worksite _____ School/child care name _____

Birth date ___/___/___ Age _____
Gender ☐ F ☐ M ☐ Other ☐ Unk
Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino
Race (check all that apply)
☐ Amer Ind/AK Native ☐ Asian
☐ Native HI/other PI ☐ Black/Afr Amer
☐ White ☐ Other

## CLINICAL INFORMATION

Onset date: ___/___/___ ☐ Derived Diagnosis date: ___/___/___ Illness duration: _____ days

### Signs and Symptoms

| Y | N | DK | NA | |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | **Poor feeding** |
| ☐ | ☐ | ☐ | ☐ | **Constipation** |
| ☐ | ☐ | ☐ | ☐ | Weakness |
| ☐ | ☐ | ☐ | ☐ | Head drooping |
| ☐ | ☐ | ☐ | ☐ | Eyelids drooping (ptosis) |
| ☐ | ☐ | ☐ | ☐ | Cry weak or altered |
| ☐ | ☐ | ☐ | ☐ | Breathing difficulty or shortness of breath |
| ☐ | ☐ | ☐ | ☐ | Diarrhea Maximum # of stools in 24 hours: ____ |

### Predisposing Conditions

| Y | N | DK | NA | |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | Preexisting injury, wound, or break in skin |
| ☐ | ☐ | ☐ | ☐ | Gastric surgery or gastrectomy in past |

### Clinical Findings

| Y | N | DK | NA | |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | **Floppy or weak baby** |
| ☐ | ☐ | ☐ | ☐ | **Failure to thrive** |
| ☐ | ☐ | ☐ | ☐ | **Respiratory distress** |
| ☐ | ☐ | ☐ | ☐ | Paralysis or weakness |
| | | | | ☐ Acute flaccid paralysis ☐ Asymmetric ☐ Symmetric ☐ Ascending ☐ Descending |
| ☐ | ☐ | ☐ | ☐ | Mechanical ventilation or intubation required during hospitalization |
| ☐ | ☐ | ☐ | ☐ | Admitted to intensive care unit |

### Hospitalization

| Y | N | DK | NA | |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | Hospitalized for this illness |

Hospital name _____
Admit date ___/___/___ Discharge date ___/___/___

| Y | N | DK | NA | |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | Died from illness Death date ___/___/___ |
| ☐ | ☐ | ☐ | ☐ | Autopsy Place of death _____ |

### Laboratory

P = Positive O = Other
N = Negative NT = Not Tested
I = Indeterminate

Collection date ___/___/___
Source _____

| P | N | I | O | NT | |
|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ | **Botulinum toxin detection (serum or stool)** ☐ Serum ☐ Stool |
| ☐ | ☐ | ☐ | ☐ | ☐ | ***C. botulinum* isolation (stool)** |
| ☐ | ☐ | ☐ | ☐ | ☐ | Food specimen submitted for testing |

Toxin type: ☐ **A** ☐ **B** ☐ **C** ☐ **D** ☐ **E** ☐ **F** ☐ **G** ☐ **Unknown**

## NOTES

Case defining variables are in **bold.** Answers are: Yes, No, Unknown to case, Not asked /Not answered

## INFECTION TIMELINE

***Enter onset date/time (first sx) in heavy box. Count backward to determine probable exposure period***

| | ***Exposure period*** | | onset |
|---|---|---|---|
| *Hours from onset:* | - 168 | -12 | |
| *Calendar date/time:* | | | |

## EXPOSURE (Refer to dates above)

| Y | N | DK | NA | |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | Travel out of the state, out of the country, or outside of usual routine<br>Out of: ☐ County ☐ State ☐ Country<br>Dates/Locations: _____<br>_____<br>_____ |
| ☐ | ☐ | ☐ | ☐ | If infant, breast fed |
| ☐ | ☐ | ☐ | ☐ | Infant formula |
| ☐ | ☐ | ☐ | ☐ | Commercial baby food |

| Y | N | DK | NA | |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | Honey (e.g. honey-filled pacifier, honey water) |
| ☐ | ☐ | ☐ | ☐ | Corn syrup |
| ☐ | ☐ | ☐ | ☐ | Home canned food |
| ☐ | ☐ | ☐ | ☐ | Dried, preserved, or traditionally prepared meat (e.g. sausage, salami, jerky) |
| ☐ | ☐ | ☐ | ☐ | Preserved, smoked, or traditionally prepared fish |
| ☐ | ☐ | ☐ | ☐ | Known contaminated food product<br>Specify: _____ |
| ☐ | ☐ | ☐ | ☐ | Source of Botulism exposure identified<br>Specify: _____ |

**Where did exposure probably occur?** ☐ In WA (County: _____) ☐ US but not WA ☐ Not in US ☐ Unk

**Exposure details:** _____

☐ **No risk factors or exposures could be identified**

☐ **Patient could not be interviewed**

## PATIENT PROPHYLAXIS AND TREATMENT

Botulism antiserum given ☐**Y** ☐**N** ☐**DK** ☐**NA** Date/time given: ___/___/___ _____ AM / PM

## PUBLIC HEALTH ISSUES

## NOTES

**Investigator** _____ **Phone/email:** _____ **Investigation complete date** ___/___/___

**Local health jurisdiction** _____ **Record complete date** ___/___/___

Botulism, infant: case defining variables are in **bold.** Answers are: Yes, No, Unknown to case, Not asked /Not answered